STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00085791 and IN00085965. Complaint IN00085791 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F225, F226, F309, and F333. Complaint IN00085965 - Unsubstantiated, due to lack of evidence. Survey dates: February 21, 22, 23, 24, 25, 2011 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Survey team: Chuck Stevenson RN Kimberly Perigo RN (February 22, 23, 24, 2011) Census bed type: SNF: 10 SNF/NF: 64 Total: 74 Census payor type: Medicare: 16 Medicaid: 58 Total: 74	F0000	The creation and submission of thi plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requiests that the 2567 plan of correction be considered the letter of credible allegation and request a Desk Review on or after 3/20/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Sample: 15 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/04/11 by Suzanne Williams, RN			

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F0157 SS=D	Based on record review and interview, the facility failed to ensure a resident's physician was notified of a significant medication error (the failure to give 4 consecutive weekly doses of Avonex, a form of Interferon, given by injection for reducing episodes of exacerbation of multiple sclerosis), for 1 of 3 residents in a sample of 15 (Resident G) reviewed for medication administration compliance. Findings Include: A facility policy titled "General Guidelines for Administrating Medication" dated 7/26/06 received form the Director of Nursing (D.O.N.) on 2/23/2011 at 11:30 a.m. and indicated to be the facility's current medication administration policy indicated: "Policy: Medications are administered as prescribed...in accordance with documented nursing principles and practices." A facility policy titled "Medication Discrepancy Report" dated 1/07 received form the Director of Nursing (D.O.N.) on 2/23/2011 at 11:30 a.m. and indicated to be the facility's current medication discrepancy reporting policy indicated:	F0157	F157 Notification of Changes It is the practicew of this provider to ensure that the attending physician is immediately informed change of condition in a residents physical, mental, or psychosocial status deteriorate. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: * Resident G physician was otified of alleged deficient practice. * Family was notified of alleged deficient practice. * The medication was obtained and administered.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: * Facility wide audit was completed to identify others who have the potential to be affext by the same alleged deficient practice. * No other residents were identified.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur * Notification of change of condition in residents will be reviewed daily Monday thru Friday except weekends and holidays. * Change of condition CQI will be completed weekly x 4, monthly x 2 and quarterly thereafter. *Staff will be inserviced on change of condition on 3/17/11.How the corretive action will be monitored to ensure the deficient practice	03/20/2011

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	"Policy:...An error shall be defined as any variation in administration of medication from the physicians (sic) orders... Procedure: Notify the physician/alternate physician, Director of Nursing and consultant pharmacist..." The record of Resident G was reviewed on 2/22/2011 at 1:45 p.m., and again on 2/25/2011 at 10:30 a.m. Diagnoses included, but were not limited to, multiple sclerosis, schizophrenia, diabetes mellitus, hypothyroidism, and constipation. A physician's order originally dated 6/06/2000 and renewed on the January and February 2011 Recapitulation of Physician's Orders indicated "Avonex prefilled syr (syringe) 30 MCG (micrograms) Inject IM (intramuscularly) every week on Thurs (Thursday)...Multiple Sclerosis." Review of resident G's Medication Administration Records for January and February 2011 indicated Resident G did not receive Avonex injections as ordered on 1/27/2011, 2/03/2011, 2/10/2011, and 2/17/2011. The record did not document any notification of the physician or		will not recur: * Director of nursing or designee will monitor results and makeappropriate corrections. * Results will be brought to the Quality Assurance meetings for continued monitoring.Compliance date: 3/20/11	

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	D.O.N. of the missed medications on any of these dates. During an interview on 2/22/2011 at 2:25 p.m. the D.O.N. indicated she had not been notified of the missed medications by any staff member and was unaware resident G had not received the Avonex as ordered. She stated "There's no excuse for that." This federal tag relates to complaint IN00085791. 3.1-5(a)(3)			

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F0225 SS=D	Based on interview and record review, the facility failed to ensure a significant medication error (the failure to give 4 consecutive weekly doses of Avonex, a form of Interferon, given by injection for reducing episodes of exacerbation of multiple sclerosis) was thoroughly investigated and reported to the State Agency in accordance with State law for 1 of 3 residents in a sample of 15 reviewed for investigating and reporting unusual occurrences. (Resident G) Findings include: The record of Resident G was reviewed on 2/22/2011 at 1:45 p.m., and again on 2/25/2011 at 10:30 a.m. Diagnoses included, but were not limited to, multiple sclerosis, schizophrenia, diabetes mellitus, hypothyroidism, and constipation. A physician's order originally dated 6/06/2000 and renewed on the January and February 2011 Recapitulation of Physician's Orders indicated "Avonex prefilled syr (syringe) 30 MCG (micrograms) Inject IM (intramuscularly) every week on Thurs (Thursday)...Multiple Sclerosis."	F0225	F225: Investigate/Report AllegationsIt is the practice of this provider to ensure that all alleged violations involving mistreatment, neglect or abuse icluding injuries of unknown sources and misappropriations of resident property by reported.What corrective action will be accomplished for those residents found to have been affected by the alleged dificient practice: * Investigation of alleged deficient practice with resident G was completed. * Allegation was reported in accordance with the state law. * Physician was notified. How will you identify other resdients having the potential to be affected by the same alleged deficient practice and what corrective action will be taken: * Residents residing at the facility have the potential to be affected by the alleged deficient practice. * A facility wide audit was completed to identify others that may be affected. * No other residents were identified. What measures will be put into place or what systemic changes you will make to ensure that the allged deficient practice does not recur: * Staff will be inserviced on 3/17/11 on abuse, residents rights, and medication errors. * Resident rights CQI will be completed by Social Service weekly x 4, monthly x 2 and quaeterly thereafter. How the corrective action will be monitored	03/20/2011

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	The Nursing Spectrum 2010 Handbook indicated: "Avonex-interferon...Indication: To reduce frequency of exacerbations in relapsing-remitting multiple sclerosis. Also inhibits proliferation of T-cells." A Health Care Plan for Resident G, most recently updated 7/15/2010, indicated: "Related Diagnosis: Multiple Sclerosis Problem Onset: 02/03/2009 Goal: Resident will be free of complications through next assessment... Approaches:...Administer Avonex as ordered..." Review of resident G's Medication Administration Records for January and February 2011 indicated Resident G did not receive Avonex injections as ordered on 1/27/2011, 2/03/2011, 2/10/2011, and 2/17/2011. The record did not document any notification of the physician or D.O.N. of the missed medications on any of these dates. During an interview on 2/22/2011 at 2:25 p.m., the D.O.N. indicated she was unaware resident G had not received the		to ensure the deficient practice will not recur 1.e. what quality assurance program will be put into place: * ED/DON or designee will monitor completion of CQI tools. * Result will be brought to the Quality Assurnce meetings for continued review.Compliance date: 3/20/11	

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	Avonex as ordered. She stated "There's no excuse for that." During an interview with the Administrator and D.O.N. on 02/25/2011 at 11:45 a.m., the D.O.N. indicated that there was no documentation of any investigation into the incident of Resident G not being administered her Avonex, that no staff interviews were documented, and that no incident report had been completed. The Administrator indicated the incident had not been reported to the State Agency. The Administrator asked the D.O.N. if this should have been reported, and the D.O.N. responded "Yes, it should have." This federal tag relates to complaint IN00085791. 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=D	Based on interview and record review, the facility failed to ensure a significant medication error (the failure to give 4 consecutive weekly doses of Avonex, a form of Interferon, given by injection for reducing episodes of exacerbation of multiple sclerosis) was thoroughly investigated and reported to the State Agency in accordance with facility policy for 1 of 3 residents in a sample of 15 reviewed for investigating and reporting unusual occurrences. Findings Include: 1. A facility policy titled "Reportable Unusual Occurrences" revised 01/25/06 received from the Administrator on 2/25/11 at 12:45 p.m. and identified as a current facility policy indicated: "Purpose: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws. Policy: All unusual occurrences reported to the State Department of Health will be recorded and tracked or monitored to insure residents are receiving appropriate care and services. Procedure: Occurrences to be reported:	F0226	F226: Develop/Implement Abuse/Neglect, ETC policyIt is the practice of this provider to ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown sources and misappropriations of resident property by reported. What corrective action will be accomplished for thoe residents found to have been affected by the alleged deficient practice: * Investigation of alleged deficient practice with resident G was completed. * Allegation was reported in accordance with the state law. * Physician was notified.How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken: * Residents residing at the facility have the potential to be affected by the alleged deficient practice. * A facility wide audit was completed to identify others that may be affected.What measures will be put into place or what systemic changes you will mae to ensure that the alleged deficient practice does not recur: * Staff will be inserviced on 3/17/11 on abuse, resdients rights, and meidication errors. * Residents rights CQI will be completed by Social SErvice weekly x 4, monthly x 2 and quarterly thereafter.How the corrective action will be monitored to ensure	03/20/2011

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	Facilities are required by law to report unusual occurrences within 24 hours to the Long Term Care Division." A facility policy titled "Reporting and Analyzing Facility Incidents" revised 01/07 received from the Administrator on 2/21/11 at 2:30 p.m. and identified as a current facility policy indicated: "Policy: The purpose of reporting facility incidents in a prescribed format and procedure is to assist in the treatment and management of residents by analyzing incidents... Responsibility: Administrator, Director of Nursing, Charge Nurse, Quality Assurance Committee and Department Heads. Definitions: Incident: An incident is an occurrence not consistent with the routine operation of the facility or the routine care of a particular resident. Procedure: The Charge Nurse at the time of an incident is responsible to complete the Incident Documentation and Investigation Tool and communicate to the Supervisor...The Charge Nurse will notify the Director of Nursing/Administrator in a timely manner...the Director of Nursing or		the deficient practice will not recur i.e.what quality assurance program will be put into place: * ED/DON or designee will monitor completion of CQI tools. *Result will be brought to the Quality Assurance meetings for cotinue review.Compliance date: 3/20/11	

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	Designee shall be responsible to notify the appropriate State agency..." A facility policy titled "Incident Documentation and Investigation" dated 11/05 received from the Administrator on 2/21/11 at 2:30 p.m. and identified as a current facility policy indicated: "Policy: All incidents involving resident care will be investigated and documented on the Incident Documentation and Investigation tool to enable the facility to evaluate care given to residents...an "incident" is any occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident... Procedure: Completing the Incident Documentation and Investigation Form:...The charge Nurse at the time of the resident care incident is responsible for conducting an investigation of the circumstances surrounding the incident, and for notifying the Director of Nursing and/or Administrator...The Charge Nurse at the time of the incident is responsible to complete the Incident Documentation and Investigation Tool...The Charge Nurse at the time of the incident is responsible for documenting the incident in the resident's medical record..."			

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The record of Resident G was reviewed on 2/22/2011 at 1:45 p.m., and again on 2/25/2011 at 10:30 a.m.

Diagnoses included, but were not limited to, multiple sclerosis, schizophrenia, diabetes mellitus, hypothyroidism, and constipation.

A physician's order originally dated 6/06/2000 and renewed on the January and February 2011 Recapitulation of Physician's Orders indicated "Avonex prefilled syr (syringe) 30 MCG (micrograms) Inject IM (intramuscularly) every week on Thurs (Thursday)...Multiple Sclerosis."

The Nursing Spectrum 2010 Handbook indicated:
"Avonex-interferon...Indication: To reduce frequency of exacerbations in relapsing-remitting multiple sclerosis. Also inhibits proliferation of T-cells."

A Health Care Plan for Resident G, most recently updated 7/15/2010, indicated:

"Related Diagnosis: Multiple Sclerosis

Problem Onset: 02/03/2009

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	Goal: Resident will be free of complications through next assessment... Approaches:...Administer Avonex as ordered..." Review of resident G's Medication Administration Records for January and February 2011 indicated Resident G did not receive Avonex injections as ordered on 1/27/2011, 2/03/2011, 2/10/2011, and 2/17/2011. The record did not document any notification of the physician or D.O.N. of the missed medications on any of these dates. During an interview on 2/22/2011 at 2:25 p.m., the D.O.N. indicated she was unaware resident G had not received the Avonex as ordered. She stated "There's no excuse for that." A second review of Resident G's record on 2/25/11 at 10:30 a.m. found no documentation of any investigation into the incident of the missed Avonex doses, no completed Incident Documentation and Investigation Form, and no indication that the resident had been assessed for potential outcomes from this incident. During an interview with the Administrator and D.O.N. on 02/25/2011 at 11:45 a.m., the D.O.N. indicated that there was no documentation of any			

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	investigation into the incident of Resident G not being administered her Avonex, that no staff interviews were documented, and that no incident report had been completed. The Administrator indicated the incident had not been reported to the State Agency. The Administrator asked the D.O.N. if this should have been reported, and the D.O.N. responded "Yes, it should have." This federal tag relates to complaint IN00085791. 3.1-28(a)			

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F0309 SS=E	Based on record review and interview, the facility failed to ensure a resident (Resident G) received necessary care to attain or maintain the highest practicable physical well-being by failing to administer medications as ordered by the physician (the failure to give 4 consecutive weekly doses of Avonex, a form of Interferon, given by injection for reducing episodes of exacerbation of multiple sclerosis) for 1 of 3 residents in a sample of 15 reviewed for medication administration compliance. Findings Include: A facility policy titled "General Guidelines for Administrating Medication" dated 7/26/06 received form the Director of Nursing (D.O.N.) on 2/23/2011 at 11:30 a.m. and indicated to be the facility's current medication administration policy indicated: "Policy: Medications are administered as prescribed...in accordance with documented nursing principles and practices." The record of Resident G was reviewed on 2/22/2011 at 1:45 p.m., and again on 2/25/2011 at 10:30 a.m.	F0309	F309: Provide Care/Services for Highest Well BeingIt is the practice of this provider the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being.What corrective action will be accomplished for those residents found to have been affected by the deficient practice: * Residents physician was notified of alleged deficient practice. * An assessment of resident G was completed on 2/25/11 to identify any decline.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: * Residents residing in facility have the ability to be affected. * A facility wide audit was completed to identify any others that may be affected by same alleged deficient practice, * No other residents were identified.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: * Staff will be inserviced on 3/17/11 on policy and procedure as related to services needed by residents. * New admission and existing residents will be monitored for needs and services upon admission, quarterly and as indicated by change of conditions.How the corrective	03/20/2011

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HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Diagnoses included, but were not limited to, multiple sclerosis, schizophrenia, diabetes mellitus, hypothyroidism, and constipation. A physician's order originally dated 6/06/2000 and renewed on the January and February 2011 Recapitulation of Physician's Orders indicated "Avonex prefilled syr (syringe) 30 MCG (micrograms) Inject IM (intramuscularly) every week on Thurs (Thursday)...Multiple Sclerosis." The Nursing Spectrum 2010 Handbook indicated: "Avonex-interferon...Indication: To reduce frequency of exacerbations in relapsing-remitting multiple sclerosis. Also inhibits proliferation of T-cells." A Health Care Plan for Resident G, most recently updated 7/15/2010, indicated: "Related Diagnosis: Multiple Sclerosis Problem Onset: 02/03/2009 Goal: Resident will be free of complications through next assessment... Approaches:...Administer Avonex as ordered..."		action will be monitor to ensure the deficient practice does not recir: * DON/ADON or designee will monitor for completion. * Results will be brought to the Quality Assurance meetings for reviiew. Compliance date: 3/20/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Review of resident G's Medication Administration Records for January and February 2011 indicated Resident G did not receive Avonex injections as ordered on 1/27/2011, 2/03/2011, 2/10/2011, and 2/17/2011. The record did not document any notification of the physician or D.O.N. of the missed medications on any of these dates. During an interview on 2/22/2011 at 2:25 p.m., the D.O.N. indicated she was unaware resident G had not received the Avonex as ordered. She stated "There's no excuse for that." This federal tag relates to complaint IN00085791. 3.1-37(a)			

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F0333 SS=E	Based on record review and interview, the facility failed to ensure a resident (Resident G) was protected from a significant medication error (the failure to give 4 consecutive weekly doses of Avonex, a form of Interferon, given by injection for reducing episodes of exacerbation of multiple sclerosis) as ordered by the physician for 1 of 3 residents in a sample of 15 reviewed for medication administration compliance. Findings Include: A facility policy titled "General Guidelines for Administration" dated 7/26/06 received form the Director of Nursing (D.O.N.) on 2/23/2011 at 11:30 a.m. and indicated to be the facility's medication administration policy indicated: "Policy: Medications are administered as prescribed...in accordance with documented nursing principles and practices." The record of Resident G was reviewed on 2/22/2011 at 1:45 p.m., and again on 2/25/2011 at 10:30 a.m. Diagnoses included, but were not limited to, multiple sclerosis, schizophrenia,	F0333	F333: Residents Free of Significant Medication Errors:It is the practice of this provider to ensure that residents are free of any significant medication error. What corrective action will be accomplished for those residents found to have been affectied by the deficient practice: * Resident's physician was notified of alleged deficient practice. * The medication was obtained and administered. * Resident was assessed for decline in function. How will you idenfity other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: *Residents residing in facility have the ability to be affected. * A facility wide audit was completed to identify any others that may be affectd by same alleged deficient practice. * No other residents were identified, What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: * Staff were inserviced on 2/22/11 on proper medication pass and procedure for missing medication. * New admissions and existing residents medications will be monitored for correct medication, dose, and schedule. * Medication administration record and Treatment administration record will be reviewed 3 x weekly by unit managers. * Medication	03/20/2011

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	diabetes mellitus, hypothyroidism, and constipation. A physician's order originally dated 6/06/2000 and renewed on the January and February 2011 Recapitulation of Physician's Orders indicated "Avonex prefilled syr (syringe) 30 MCG (micrograms) Inject IM (intramuscularly) every week on Thurs (Thursday)...Multiple Sclerosis." The Nursing Spectrum 2010 Handbook indicated: "Avonex-interferon...Indication: To reduce frequency of exacerbations in relapsing-remitting multiple sclerosis. Also inhibits proliferation of T-cells." Review of resident G's Medication Administration Records for January and February 2011 indicated Resident G did not receive Avonex injections as ordered on 1/27/2011, 2/03/2011, 2/10/2011, and 2/17/2011. The record did not document any notification of the physician or D.O.N. of the missed medications on any of these dates. During an interview on 2/22/2011 at 2:25 p.m., the D.O.N. indicated she was unaware resident G had not received the Avonex as ordered. She stated "There's no		Error CQI will be completed by DON/designee weely x 4, monthly x 2 and quarterly thereafter. How the corrective action will be monitored to ensure the deficient practice will not recir: * DON/ADON or designee will monitor for completion. * Result will be brought to the Quality Assurance meetings for review. Compliance date: 3/20/11	

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	excuse for that." This federal tag relates to complaint IN00085791. 3.1-25(a) 3.1-25(b)(9)			